

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

43697

State File No.

269

FILED JAN 26 1951 **318** **1003** **REG. DIST. NO.** **PRIMARY REG. DIST. NO.** **Registrar's No.**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) a. STATE		b. COUNTY	
b. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.		c. LENGTH OF STAY (in this place)		c. CITY (If outside corporate limits, write RURAL and give township) St. Louis, Mo.	
d. FULL NAME OF HOSPITAL OR INSTITUTION Hosp =		d. STREET ADDRESS 3716 Rutger			
3. NAME OF DECEASED (Type or Print) Mary		a. (First)		b. (Middle)	
c. (Last) Kathleen		4. DATE OF DEATH January 5, 1951		(Month) (Day) (Year)	
5. SEX Female		6. COLOR OR RACE Sol.		7. MARRIED, NEVER MARRIED, WIDOWED, DIVORCED (Specify)	
8. DATE OF BIRTH Apr 18, 1875		9. AGE (in years last birthday) 75		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY? 0			
13a. FATHER'S NAME Wick		13b. MOTHER'S MAIDEN NAME Wick		14. NAME OF HUSBAND OR WIFE Wick	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give date of service) Wick		16. SOCIAL SECURITY NO. Wick		17. INFORMANT'S SIGNATURE OR NAME P. E. Vaylor	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) *This does not mean the mode of dying, such as heart failure, asphyxia, etc. It means the disease, injury, or complication which caused death.		19. MEDICAL CERTIFICATION a. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH* (a) ANTECEDENT CAUSES Morbidity conditions, if any, giving rise to the above cause (a) stating the underlying cause last. DUE TO (b) DUE TO (c) b. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT SUICIDE HOMICIDE (Specify)		21b. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21c. (CITY, TOWN, OR TOWNSHIP) (COUNTY) (STATE)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? 3716 X	
22. I hereby certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ m., from the causes and on the date stated above.					
23a. SIGNATURE (Degree or title) J. B. Fasata		23b. ADDRESS 1300 Clark		23c. DATE SIGNED 1/5/51	
24a. BURIAL, CREMATION, REMOVAL (Specify) Burial		24b. DATE JAN 1 1951		24c. NAME OF CEMETERY OR CREMATORY Anatomical Board	
24d. LOCATION (City, town, or county) (State)		25. FUNERAL DIRECTOR'S SIGNATURE Rowland Mortuary Service Inc.		ADDRESS	

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by

Students of Mortuary College
working under my personal supervision.

Student Embalmer No.

Signed.....
Student Embalmer

Signed

James H. Lammers
Licensed Embalmer No. *4142*

P. O. Address *St. Louis*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.